

EXHIBIT 6

**WHOLE FOODS MARKET
GROUP BENEFIT PLAN**

**Amended and Restated
Effective January 1, 2012**

WHOLE FOODS MARKET GROUP BENEFIT PLAN

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WHOLE FOODS MARKET GROUP BENEFIT PLAN

ARTICLE I ESTABLISHMENT AND INTERPRETATION OF THE PLAN

1.1 The Plan. The Plan is hereby amended and restated, effective January 1, 2012.

1.2 Purpose. The purpose of this Plan is to provide Team Members and their Dependents and Beneficiaries certain health and welfare benefits as described herein. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA and the Code except, for purposes of Article VII, all Health Programs shall be treated as a single plan separate from all non-Health Programs. The Plan is intended to meet all applicable requirements of ERISA and the Code, as well as rulings and regulations issued or promulgated thereunder.

1.3 Definitions. The following terms, where capitalized, shall have the meanings as set forth below unless otherwise specified herein:

(a) "Affiliate" means a member of a controlled group of corporations (as defined in Section 414(b) of the Code), a group of trades or businesses (whether or not incorporated) that are under common control (as defined in Section 414(c) of the Code), or an affiliated service group (as defined in Section 414(m) of the Code) of which the Company is a member.

(b) "Affidavit of Domestic Partnership" means a written, notarized affidavit attesting to the Domestic Partnership of the Team Member and his or her Domestic Partner.

(c) "Alternate Recipient" means any child of a Team Member or Former Team Member who is a Participant and who, pursuant to a Medical Child Support Order determined by the Committee or its authorized delegate to be qualified, is recognized as having a right to enrollment under a Welfare Benefit Program with respect to such Participant.

(d) "Beneficiary" means an individual, other than a Team Member, Former Team Member or Dependent, who meets the requirements for coverage under the applicable Benefit Program.

(e) "Benefit Program" means a Fringe Benefit Program or Welfare Benefit Program. Each Benefit Program under the Plan is identified in Appendix A.

(f) "Board" means the Board of Directors of the Company or its authorized delegate.

(g) "Cafeteria Plan" means the plan designated as the Cafeteria Plan on Appendix A, which is maintained by the Company for the purpose of providing eligible

Team Members with a choice to receive one or more benefits available under certain Benefit Programs hereunder in lieu of compensation, as set forth in this plan document or such Benefit Program, as amended from time to time, the terms of which are incorporated herein by reference.

(h) "Claims Administrator" shall mean any insurance company or other entity or entities responsible for determining benefit eligibility and adjudicating claims under a Benefit Program or, if none is appointed, the Plan Administrator.

(i) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(j) "Code" means the Internal Revenue Code of 1986, as amended.

(k) "Committee" means the Whole Foods Market, Inc. Benefits Administrative Committee or, in the event such committee no longer exists or to the extent such committee is no longer authorized to administer this Plan or any Benefit Program, such other person or persons appointed by the Board to administer the Plan or such Benefit Program, if none has been appointed, the Board.

(l) "Company" means Whole Foods Market, Inc. and any successor or successors that continue to maintain the Plan.

(m) "Component Plan" means, with respect to each Benefit Program (or group of Benefit Programs treated as a single plan for purposes of satisfying applicable nondiscrimination requirements), those benefits that are available to all Participants in the same amount and subject to the same participation requirements.

(n) "Coverage Plan" means, for purposes of the coordination of benefits provisions of Article VIII hereof, the following plans or contracts (or portions thereof) providing benefits or services for medical, dental and vision care or treatment:

(i) Group insurance, closed panel, or other forms of group or group-type coverage, whether on an insured or uninsured basis.

(ii) Medical care components of group long-term care contracts, such as skilled nursing care.

(iii) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid or TRICARE, to the extent permitted by law.

(iv) Medical benefits available under group or individual automobile insurance coverage (including no-fault coverage and uninsured motorist coverage), based upon the maximum coverage available in the Participant's state of residence, whether or not the Participant is in compliance with the law, or whether or not the maximum coverage is carried.

(o) "Covered Entity" shall mean a health plan, a health care clearinghouse, a Health Care Provider that conducts certain transactions, as specified in the HIPAA Regulations, in electronic form and an endorsed sponsor of a Medicare prescription drug discount card.

(p) "Dental Plan" means the plan or plans designated as the Dental Plan on Appendix A, which is maintained by the Company for the purpose of providing dental benefits to eligible Team Members and their eligible Dependents and Beneficiaries, as set forth in this plan document, a summary plan description and/or one or more insurance contracts, as amended from time to time, the terms of which are incorporated herein by reference.

(q) "Dependent" means a Spouse and any other individual who otherwise meets the definition of "dependent" under the applicable Benefit Program. A "Dependent" of a Group Health Plan shall include an Alternate Recipient entitled to receive coverage hereunder pursuant to the terms of a QMCSO.

(r) "Domestic Partner" means a person of the opposite or same sex with whom, based on such proof and documentation as the Plan Administrator, in its sole and absolute discretion, may require, the Team Member has established a Domestic Partnership.

(s) "Domestic Partnership" means an exclusive relationship between a Team Member and an individual who:

(i) is an unmarried adult at least 18 years of age (19 years of age in the State of Minnesota);

(ii) is not related to the Team Member by blood closer than permitted by applicable state law for marriages;

(iii) has either resided with the Team Member for at least twelve (12) consecutive months or held joint title to a residence with the Team Member for at least six (6) months; and

(iv) shares a committed, financially interdependent relationship that is intended to last indefinitely, as evidenced by an Affidavit of Domestic Partnership signed by the parties.

(t) "Effective Date" means January 1, 2012, except as otherwise provided herein.

(u) "Employer" means the Company and each Affiliate that is designated by the Company to participate in this Plan pursuant to Article X hereof. A list of the Employers participating in the Plan is included as Appendix B hereto.

(v) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

- (w) "FMLA" means the Family Medical Leave Act of 1993, as amended.
- (x) "Former Team Member" means any Team Member who has terminated employment with all Employers.
- (y) "Fringe Benefit Program" means a written arrangement incorporated under this Plan that is offered by the Company and that provides an employee benefit that does not constitute a Welfare Benefit Program.
- (z) "Genetic Information" means, except as otherwise provided by applicable law, mean, with respect to each Participant, (i) such Participant's genetic tests; (ii) the genetic tests of family members of such Participant; (iii) the manifestation of a disease or disorder in family members of such Participant and (iv) any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the Participant or any family member of such Participant. The term "Genetic Information" includes information about a Participant's or family member's fetus or embryo. The term "Genetic Information" does not include information about the sex or age of any individual.
- (aa) "Group Health Plan" means a Welfare Benefit Program that is a "group health plan" as defined under Section 9832 of the Code or Section 733(a), subject to the exceptions provided under Section 9831 of the Code and Section 732 of ERISA, as applicable. Notwithstanding the foregoing, however, with respect to Section 9.13 hereof, the term "Group Health Plan" means a Welfare Benefit Program that is a "group health plan" as defined under Section 9802(e) of the Code or Section 702(e) of ERISA.
- (bb) "Health Care Operations" shall mean activities of the Plan, other than Payment or Treatment, which are compatible with or directly related to Payment or Treatment, such as conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment, reviewing and evaluating qualifications and/or health plan performance, securing contracts for reinsurance, conducting or arranging for medical review or auditing functions (including fraud and abuse detection), and business planning and development (including methods of payment or coverage policies) and similar activities described under the HIPAA Regulations.
- (cc) "Health Care Provider" shall mean a provider of medical or other services, or one that furnishes medical or health care services or supplies (as defined in Sections 1861(s) and (u) of the Social Security Act).
- (dd) "Health Plan" means the plan or plans designated as the Health Plan on Appendix A, which is maintained by the Company for the purpose of providing medical benefits to eligible Team Members and their eligible Dependents and Beneficiaries, as set forth in this plan document, the applicable summary plan description and/or one or more

insurance contracts, as amended from time to time, the terms of which are incorporated herein by reference.

(ee) "Health Program" shall mean each Welfare Benefit Program that is subject to the HIPAA Regulations.

(ff) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

(gg) "HIPAA Regulations" shall mean the privacy and security regulations promulgated under HIPAA.

(hh) "Individually Identifiable Health Information" means information that (i) is created or received by a Health Program, (ii) relates to the past, present, or future physical or mental health or condition of a Participant (whether living or deceased); the provision of health care to a Participant; or the past, present, or future Payment for the provision of health care to a Participant, and (iii) either identifies the Participant or with respect to which there is a reasonable basis to believe the information can be used to identify the Participant.

(ii) "Hour of Service" means each hour for which a Team Member is directly or indirectly paid or entitled to payment by an Employer for the performance of duties, as reflected on the Team Member's paycheck stub, excluding hours for which the Team Member received paid time off and overtime.

(jj) "Life and AD&D Plan" means the plan or plans designated as the Life and AD&D Plan on Appendix A, which is maintained by the Company for the purpose of providing life insurance and accidental death and dismemberment benefits to eligible Team Members, as set forth in this plan document, the applicable summary plan description and/or one or more insurance contracts, as amended from time to time, the terms of which are incorporated herein by reference.

(kk) "Long-Term Disability Plan" means the plan or plans designated as the Long-Term Disability Plan on Appendix A, which is maintained by the Company for the purpose of providing long-term disability benefits to eligible Team Members, as set forth in this plan document, the applicable summary plan description and/or one or more insurance contracts, as amended from time to time, the terms of which are incorporated herein by reference.

(ll) "Medical Child Support Order" shall mean any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which (i) provides for child support with respect to a child of a Team Member or Former Team Member who is a Participant under this Plan or provides for health benefit coverage to such a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under this Plan, or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of OBRA '93) with respect to this Plan.